26-40-101. Title.

This chapter is known as the "Utah Children's Health Insurance Act."

Enacted by Chapter 360, 1998 General Session

26-40-102. Definitions.

As used in this chapter:

(1) "Child" means a person who is under 19 years of age.

(2) "Eligible child" means a child who qualifies for enrollment in the program as provided in Section 26-40-105.

(3) "Enrollee" means any child enrolled in the program.

(4) "Plan" means the department's plan submitted to the United States Department of Health and Human Services pursuant to 42 U.S.C. Sec. 1397ff.

(5) "Program" means the Utah Children's Health Insurance Program created by this chapter.

Amended by Chapter 1, 2000 General Session
Amended by Chapter 351, 2000 General Session

26-40-103. Creation and administration of the Utah Children's Health Insurance Program.

(1) There is created the Utah Children's Health Insurance Program to be administered by the department in accordance with the provisions of:

(a) this chapter; and

(b) the State Children's Health Insurance Program, 42 U.S.C. Sec. 1397aa et seq.

(2) The department shall:

(a) prepare and submit the state's children's health insurance plan before May 1, 1998, and any amendments to the federal Department of Health and Human Services in accordance with 42 U.S.C. Sec. 1397ff; and

(b) make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act regarding:

(i) eligibility requirements consistent with Subsection 26-18-3(8);

(ii) program benefits;

(iii) the level of coverage for each program benefit;

(iv) cost-sharing requirements for enrollees, which may not:

(A) exceed the guidelines set forth in 42 U.S.C. Sec. 1397ee; or

(B) impose deductible, copayment, or coinsurance requirements on an enrollee for well-child, well-baby, and immunizations;

(v) the administration of the program; and

(vi) a requirement that:

(A) enrollees in the program shall participate in the electronic exchange of clinical health records established in accordance with Section 26-1-37 unless the enrollee opts out of participation;

(B) prior to enrollment in the electronic exchange of clinical health records the enrollee shall receive notice of the enrollment in the electronic exchange of clinical

health records and the right to opt out of participation at any time; and

(C) beginning July 1, 2012, when the program sends enrollment or renewal information to the enrollee and when the enrollee logs onto the program's website, the enrollee shall receive notice of the right to opt out of the electronic exchange of clinical health records.

Amended by Chapter 167, 2013 General Session

26-40-104. Utah Children's Health Insurance Program Advisory Council.

(1) There is created a Utah Children's Health Insurance Program Advisory Council consisting of at least eight and no more than 11 members appointed by the executive director of the department. The term of each appointment shall be three years. The appointments shall be staggered at one-year intervals to ensure continuity of the advisory council.

(2) The advisory council shall meet at least quarterly.

(3) The membership of the advisory council shall include at least one representative from each of the following groups:

(a) child health care providers;

(b) parents and guardians of children enrolled in the program;

(c) ethnic populations other than American Indians;

(d) American Indians;

(e) the Utah Association of Health Care Providers;

(f) health and accident and health insurance providers; and

(g) the general public.

(4) The advisory council shall advise the department on:

(a) benefits design;

(b) eligibility criteria;

(c) outreach;

(d) evaluation; and

(e) special strategies for under-served populations.

(5) A member may not receive compensation or benefits for the member's service, but may receive per diem and travel expenses in accordance with:

(a) Section 63A-3-106;

(b) Section 63A-3-107; and

(c) rules made by the Division of Finance pursuant to Sections 63A-3-106 and 63A-3-107.

Amended by Chapter 286, 2010 General Session

26-40-105. Eligibility.

(1) A child is eligible to enroll in the program if the child:

(a) is a bona fide Utah resident;

(b) is a citizen or legal resident of the United States;

(c) is under 19 years of age;

(d) does not have access to or coverage under other health insurance, including any coverage available through a parent or legal guardian's employer;

(e) is ineligible for Medicaid benefits;

(f) resides in a household whose gross family income, as defined by rule, is at or below 200% of the federal poverty level; and

(g) is not an inmate of a public institution or a patient in an institution for mental diseases.

(2) A child who qualifies for enrollment in the program under Subsection (1) may not be denied enrollment due to a diagnosis or pre-existing condition.

(3) (a) The department shall determine eligibility and send notification of the eligibility decision within 30 days after receiving the application for coverage.

(b) If the department cannot reach a decision because the applicant fails to take a required action, or because there is an administrative or other emergency beyond the department's control, the department shall:

(i) document the reason for the delay in the applicant's case record; and

(ii) inform the applicant of the status of the application and time frame for completion.

(4) The department may not close enrollment in the program for a child who is eligible to enroll in the program under the provisions of Subsection (1).

(5) (a) The program shall:

(i) apply for grants to make technology system improvements necessary to implement a simplified enrollment and renewal process in accordance with this Subsection (5); and

(ii) if funding is available, implement the simplified enrollment and renewal process in accordance with this Subsection (5).

(b) The simplified enrollment and renewal process:

(i) shall, in accordance with Section 59-1-403, provide an eligibility worker a process in which the eligibility worker:

(A) verifies the applicant's identity;

(B) gets consent to obtain the applicant's adjusted gross income from the State Tax Commission from:

(I) the applicant, if the applicant filed a single tax return; or

(II) both parties to a joint return, if the applicant filed a joint tax return; and

(C) obtains from the Utah State Tax Commission, the adjusted gross income of the applicant; and

(ii) may not change the eligibility requirements for the program.

Amended by Chapter 344, 2011 General Session

26-40-106. Program benefits.

(1) Until the department implements a plan under Subsection (2), program benefits may include:

(a) hospital services;

(b) physician services;

(c) laboratory services;

(d) prescription drugs;

(e) mental health services;

(f) basic dental services;

(g) preventive care including:
(i) routine physical examinations;
(ii) immunizations;
(iii) basic vision services; and
(iv) basic hearing services;
(h) limited home health and durable medical equipment services; and
(i) hospice care.
(2) (a) Except as provided in Subsection (2)(d), no later than July 1, 2008, the medical program benefits shall be benchmarked, in accordance with 42 U.S.C. Sec. 1397cc, to be actuarially equivalent to a health benefit plan with the largest insured commercial enrollment offered by a health maintenance organization in the state.
(b) Except as provided in Subsection (2)(d), after July 1, 2012:
(i) medical program benefits may not exceed the benefit level described in Subsection (2)(a); and
(ii) medical program benefits shall be adjusted every July 1, thereafter to meet the benefit level described in Subsection (2)(a).
(c) The dental benefit plan shall be benchmarked, in accordance with the Children's Health Insurance Program Reauthorization Act of 2009, to be equivalent to a dental benefit plan that has the largest insured, commercial, non-Medicaid enrollment of covered lives that is offered in the state, except that the utilization review mechanism for orthodontia shall be based on medical necessity. Dental program benefits shall be adjusted on July 1, 2012, and on July 1 every three years thereafter to meet the benefit level required by this Subsection (2)(c).
(d) The program benefits for enrollees who are at or below 100% of the federal poverty level are exempt from the benchmark requirements of Subsections (2)(a) and (2)(b).

Amended by Chapter 279, 2012 General Session

26-40-107. Limitation of benefits.
Abortion is not a covered benefit, except as provided in 42 U.S.C. Sec. 1397ee.

Enacted by Chapter 360, 1998 General Session

26-40-108. Funding.
(1) The program shall be funded by federal matching funds received under, together with state matching funds required by, 42 U.S.C. Sec. 1397ee.
(2) Program expenditures in the following categories may not exceed 10% in the aggregate of all federal payments pursuant to 42 U.S.C. Sec. 1397ee:
(a) other forms of child health assistance for children with gross family incomes below 200% of the federal poverty level;
(b) other health services initiatives to improve low-income children's health;
(c) outreach program expenditures; and
(d) administrative costs.

Amended by Chapter 391, 2010 General Session

26-40-109. Evaluation.

The department shall develop performance measures and annually evaluate the program's performance.

Amended by Chapter 167, 2013 General Session

26-40-110. Managed care -- Contracting for services.

(1) Program benefits provided to enrollees under the program, as described in Section 26-40-106, shall be delivered in a managed care system if the department determines that adequate services are available where the enrollee lives or resides.

(2) (a) The department shall use the following criteria to evaluate bids from health plans:

(i) ability to manage medical expenses, including mental health costs;

(ii) proven ability to handle accident and health insurance;

(iii) efficiency of claim paying procedures;

(iv) proven ability for managed care and quality assurance;

(v) provider contracting and discounts;

(vi) pharmacy benefit management;

(vii) an estimate of total charges for administering the pool;

(viii) ability to administer the pool in a cost-efficient manner;

(ix) the ability to provide adequate providers and services in the state;

(x) for contracts entered into or renewed on or after January 1, 2014, the ability to meet quality measures for emergency room use and access to primary care established by the department under Subsection 26-18-408(4); and

(xi) other criteria established by the department.

(b) The dental benefits required by Section 26-40-106 may be bid out separately from other program benefits.

(c) Except for dental benefits, the department shall request bids for the program's benefits in 2008. The department shall request bids for the program's dental benefits in 2009. The department shall request bids for the program's benefits at least once every five years thereafter.

(d) The department's contract with health plans for the program's benefits shall include risk sharing provisions in which the health plan shall accept at least 75% of the risk for any difference between the department's premium payments per client and actual medical expenditures.

(3) The executive director shall report to and seek recommendations from the Health Advisory Council created in Section 26-1-7.5:

(a) if the division receives less than two bids or proposals under this section that are acceptable to the division or responsive to the bid; and

(b) before awarding a contract to a managed care system.

(4) (a) The department shall award contracts to responsive bidders if the department determines that a bid is acceptable and meets the criteria of Subsections (2)(a) and (d).

(b) The department may contract with the Group Insurance Division within the Utah State Retirement Office to provide services under Subsection (1) if:

(i) the executive director seeks the recommendation of the Health Advisory

Council under Subsection (3); and

(ii) the executive director determines that the bids were not acceptable to the department.

(c) In accordance with Section 49-20-201, a contract awarded under Subsection (4)(b) is not subject to the risk sharing required by Subsection (2)(d).

(5) Title 63G, Chapter 6a, Utah Procurement Code, shall apply to this section.

Amended by Chapter 103, 2013 General Session

26-40-115. State contractor -- Employee and dependent health benefit plan coverage.

For purposes of Sections 17B-2a-818.5, 19-1-206, 63A-5-205, 63C-9-403, 72-6-107.5, and 79-2-404, "qualified health insurance coverage" means at the time the contract is entered into or renewed:

(1) a health benefit plan and employer contribution level with a combined actuarial value at least actuarially equivalent to the combined actuarial value of the benchmark plan determined by the Children's Health Insurance Program under Subsection 26-40-106(2)(a), and a contribution level of 50% of the premium for the employee and the dependents of the employee who reside or work in the state, in which:

(a) the employer pays at least 50% of the premium for the employee and the dependents of the employee who reside or work in the state; and

(b) for purposes of calculating actuarial equivalency under this Subsection (1)(b):

(i) rather that the benchmark plan's deductible, and the benchmark plan's out-of-pocket maximum based on income levels:

(A) the deductible is $1,000 per individual and $3,000 per family; and

(B) the out-of-pocket maximum is $3,000 per individual and $9,000 per family;

(ii) dental coverage is not required; and

(iii) other than Subsection 26-40-106(2)(a), the provisions of Section 26-40-106 do not apply; or

(2) a federally qualified high deductible health plan that, at a minimum:

(a) has a deductible that is either:

(i) the lowest deductible permitted for a federally qualified high deductible health plan; or

(ii) a deductible that is higher than the lowest deductible permitted for a federally qualified high deductible health plan, but includes an employer contribution to a health savings account in a dollar amount at least equal to the dollar amount difference between the lowest deductible permitted for a federally qualified high deductible plan and the deductible for the employer offered federally qualified high deductible plan;

(b) has an out-of-pocket maximum that does not exceed three times the amount of the annual deductible; and

(c) the employer pays 60% of the premium for the employee and the dependents of the employee who work or reside in the state.

Enacted by Chapter 400, 2011 General Session

26-40-116. Program to encourage appropriate emergency room use -- Application for waivers.

The program is subject to the provisions of Section 26-18-408 and shall apply for waivers in accordance with Subsection 26-18-408(5).

Enacted by Chapter 103, 2013 General Session